CLAIM FOR ASSESSMENT
Preadmission Screening and Annual Resident Review (PASARR)

State Form 43878 (10-92) OMPP Form 3508

Approved by State Board of Accounts 1990

INSTRUCTIONS: Please read instruction on back before completing.

SECTION 1

Provider: Your Social Security number or Federal Identification number and your Medicaid Provider number are required in order for payment to be issued for this claim. W-9 must be on file at Auditor's office.

Social Security number

2 – | | | – | | | – | | | | – 0 0

Federal Identification number

1 – | | – | | | | | | | – | | |

Medicaid Provider number *(include 2 digit Alpha prefix)*

| | | | | | | | | | | | | | | |

SECTION II — **PATIENT INFORMATION**

Name of patient *(last, first, middle)*			Patient's Social Security number
			– –
Patient's street address			On Medicaid *(circle one)* / County code
City	State	ZIP code	Patient's Medicaid ID number

SECTION III A — **MR / DD ASSESSMENTS**

DATE OF SERVICE	PROCEDURE CODE	NARRATIVE DESCRIPTION	CHARGE
	9075	Initial Level II MR Screening (PAS-MR)	
	9076	Initial Level II Psych Exam (PAS-MR)	
	9077	Annual Level II MR Screening (ARR-MR)	
	9082	Annual Level II Psych Exam (ARR-MR)	
SECTION III B		**MI ASSESSMENTS**	
	9079	Initial Level II MI Screening (PAS-MI)	
	9080	Initial Level II MI Screening Update (PAS-MI)	
	9081	Annual Level II MI Screening (ARR-MI)	

SECTION IV — **PROVIDER INFORMATION**

Name of provider		
Street address of provider		
City	State	ZIP code

SECTION IV

TOTAL CHARGES

MAIL COMPLETED FORM TO:

PASARR Program
Office of Medicaid Policy & Planning
Family and Social Services Administration
402 W. Washington St., Rm. W382
Indianapolis, IN 46204

PROVIDER CERTIFICATION

Pursuant to the provisions and penalties of Indiana code 5-11-10-1, I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.

Signature	Date *(month, day, year)*

INSTRUCTIONS FOR COMPLETING OMPP FORM 3508

NOTE: A claim must be completed in its entirety before it will be processed for payment. Incomplete claims will be returned to the provider.

1. A W-9 *(Payer's Request for Tax Payer Identification Number and Certification)* must be on file at the Auditor's office. Do not submit a claim until a W-9 is on file or the claim will be returned to the provider. Mail completed W-9's to: **Auditor of State, State House, Room 146, Indianapolis, IN 46204.**
2. The **Medicaid Provider Number** must be entered on each claim.

SECTION II - PATIENT INFORMATION

1. The patient's **Social Security Number** must be entered on each claim.
2. If the patient is on Medicaid at the time of assessment *(has a valid Medicaid card for the month of assessment)* circle "1" and enter the recipient's 12 digit Medicaid number. Circle "2" if the recipient is not currently enrolled in the Medicaid Program.
3. The **"County Code"** should list the patient's county of residence at the time of assessment. Enter code "99" if the patient is an out-of-state resident at the time of assessment.

SECTION III A - (MR / DD) and B (MI) ASSESSMENTS

1. All charges must be based upon actual costs incurred by the provider. Claims are subject to State and Federal audits; therefore, providers must be prepared to show justification of charges upon request. Transportation expenses for travel to one nursing facility for the purpose of conducting assessments on more than one resident are to be billed as a total of only one round trip, rather than as a separate trip for each individual tested. Actual charges will be re-
2. The **"Date of Service"** and amount of the **"charge"** must be entered on the appropriate code line of the MR / DD or MI assessment conducted.